(OFFICE USE ONLY)	
Facility Number	

Massachusetts Division of Health Care Finance and Policy
2 Boylston Street, Boston, MA 02116
Tel (617) 988-3100 FAX (617) 727-7662 TTY (617) 988-3175

Nursing Facility Quarterly User Fee Assessment Form

Facility Name: _____ **VPN:** _____

Address: _____

City, State, Zip: _____ **Federal Tax ID#:** _____

Contact Name: _____ **Contact Phone#:** _____

The purpose of this form is to gather the necessary information to calculate your facility's User Fee Assessment in accordance with regulation 114.5 CMR 12.04 (1)&(2).

If you have any questions, please call Provider Assistance at (617) 988-3299.

I. Total Nursing Patient Days for Quarter Ending _____

Only nursing home level days should be included. Do not include resident care days.

	1	2	3	4	5	6		7
Type	**Mass. Medicaid**	**Non-Mass Medicaid**	**MA Comm For the Blind**	**VA/Other Public**	**Private**	**Medicare**		**Non-Medicare Days (Sum(1 – 5))**
Total Qtr NH Patient Days								

II. Calculation of the Nursing Facility User Fee Assessment

Total Qtr Non-Medicare Days		**User Fee Rate**		**NH User Fee**
_____ (Col. 7 above)	**X**	**10.40**	**=**	_____

III. Comments (Attach additional pages if necessary.)

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The facility representative whose signature appears below, is acknowledging to the best of his/her knowledge, by said signature, that the information in this worksheet is true, accurate, and prepared in accordance with applicable regulations and instructions under the pains of penalties of perjury.

_____ _____
Signature of Owner, Partner, Officer or Administrator Date

_____ _____
Print Name of signatory above Print Title